# Chapter 6

# Billing on the UB Claim Form

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## INTRODUCTION

The UB claim form is used to bill for all hospital inpatient, outpatient, emergency room services, Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services.

☑ Revenue codes are used to bill line-item services provided in a facility.

☑ Revenue codes must be valid for the service provided.

☑ Revenue codes also must be valid for the bill type on the claim.

- ✓ For example, hospice revenue codes 651, 652, 655, 656 can only be billed on a UB with a bill type 81X-82X (Special Facility Hospice).
- ✓ If those revenue codes are billed with a regular inpatient bill type (11X – 12X), the claim will be denied.

☑ ICD-9 diagnosis codes are required.

- ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

☑ ICD-9 procedure codes must be used to identify surgical procedures billed on the Inpatient UB.

☑ CPT/HCPCS and modifiers (as appropriate) must be used in combination with Revenue codes to identify services rendered on the Outpatient UB.

## COMPLETING THE UB CLAIM FORM

The following instructions explain how to complete the UB claim form and whether a field is "Required," "Required if applicable," or "Not required." The instructions should be used to supplement the information in the *AHA Uniform Billing Manual.*.

**NOTE:** This chapter applies to paper UB claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

## COMPLETING THE UB CLAIM FORM (CONT.)

**1. Provider Data** **Required**

Enter the name, address, and phone number of the provider rendering service.

| 1 |
|---|
| Arizona Hospital<br>123 Main Street<br>Scottsdale, AZ 85252 |

**2. Unassigned** **Not required**

**3. Patient Control No.** **Required if applicable**

This is a number that the facility assigns to uniquely identify a claim in the facility's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility's accounting or tracking system.

**4. Bill Type** **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See *AHA Uniform Billing Manual* for codes.

| 2. | 3. PATIENT CONTROL NO. | 4. TYPE OF BILL |
|---|---|---|
| | | 111 |

**5. Fed Tax No.** **Required**

Enter the facility's federal tax identification number.

| 5. FED TAX NO. | 6. STATEMENT COVERS PERIOD FROM | THROUGH | 7. COV D |
|---|---|---|---|
| 86-1234567 | | | |

## COMPLETING THE UB CLAIM FORM (CONT.)

**6. Statement Covers Period** **Required**

Enter the beginning and ending dates of the billing period.

| 5. FED TAX NO. | 6. STATEMENT COVERS PERIOD FROM | THROUGH | 7. COV D |
|---|---|---|---|
| | 02/15/03 | 02/20/03 | |

**or**

| | | | |
|---|---|---|---|
| | 02/15/2003 | 02/20/2003 | |

**7. Covered Days** **Not required**

**8. Non-covered Days** **Not required**

**9. Coinsurance Days** **Not required**

**10. Lifetime Reserve Days** **Not required**

**11. Group Provider ID** **Not required**

**12. Patient Name** **Required**

Enter the recipient's last name, first name, and middle initial as they appear on the AHCCCS ID card.

| 12 PATIENT NAME | 13 PATIENT ADDRESS |
|---|---|
| Holliday, John H. | |

**13. Patient Address** **Not required**

**14. Patient Birth Date** **Required**

Enter the month, day, century, and year (MM/DD/YYYY format) of recipient's birth.

| 14. BIRTHDATE | 15. SEX | 16. MS | ADMISSION | | | |
|---|---|---|---|---|---|---|
| | | | 17. DATE | 18. HR | 19. TYPE | 20. SRC |
| | | | | | | |

## COMPLETING THE UB CLAIM FORM (CONT.)

**15. Sex** **Required**

Enter "M" (male) or "F" (female).

| 14. BIRTHDATE | 15. SEX | 16. MS | ADMISSION | | | |
|---|---|---|---|---|---|---|
| | | | 17. DATE | 18. HR | 19. TYPE | 20. SRC |
| | M | | | | | |

**16. Marital Status** **Not required**

**17. Admission Date/Start of Care Date** **Required**

Enter the admission/start of care date in MM/DD/YY or MM/DD/YYYY format. Required for all inpatient and outpatient claims. The date the patient was admitted for Inpatient care, or the start of care date for Outpatient services.

| 14. BIRTHDATE | 15. SEX | 16. MS | ADMISSION | | | |
|---|---|---|---|---|---|---|
| | | | 17. DATE | 18. HR | 19. TYPE | 20. SRC |
| | | | 02/15/03 | | | |

**or**

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | 02/15/2003 | | | |

**18. Admission Hour** **Required if applicable**

Enter the code which best indicates recipient's time of admission. Required for inpatient claims. See *AHA Uniform Billing Manual* for codes.

| 14. BIRTHDATE | 15. SEX | 16. MS | ADMISSION | | | |
|---|---|---|---|---|---|---|
| | | | 17. DATE | 18. HR | 19. TYPE | 20. SRC |
| | | | | 19 | | |

**19. Type of Admission/Visit** **Required if applicable**

Required for all inpatient claims. An Admit Type of "1" is required for emergency inpatient and outpatient claims. See *AHA Uniform Billing Manual* for codes

## COMPLETING THE UB CLAIM FORM (CONT.)

**20. Source of Admission** **Required if applicable**

Required for all inpatient claims. Enter the code that describes the admission source See *AHA Uniform Billing Manual* for codes):

**21. Discharge Hour** **Required if applicable**

Enter the code which best indicates the recipient's time of discharge. Required for inpatient claims when the recipient has been discharged. See *AHA Uniform Billing Manual* for codes.

**22. Patient Status** **Required if applicable**

Required for all inpatient claims. Enter the code that best describes the recipient's status for this billing period. See *AHA Uniform Billing Manual* for codes.

**23. Medical Record No.** **Not required**

**24.–30. Condition Code** **Required if applicable**

Enter the appropriate condition codes that apply to this bill. See *AHA Uniform Billing Manual* for codes.

In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering "61" in any Condition Code field.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter "73" in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

To bill for multiple distinct/independent outpatient visits on the same day, facilities must enter "G0"

**31. Unassigned** **Not required**

**32.–35 (a-b) Occurrence Code and Date** **Not required**

**36. (a–b) Occurrence Span Code and Date** **Not required**

## COMPLETING THE UB CLAIM FORM (CONT.)

**37. Internal Control Number** **Not required**

**38. Responsible Party Name and Address** **Not required**

**39.**

**41. Value Codes and Amounts** **Required if applicable**

Enter the appropriate code(s) and amount(s). See *AHA Uniform Billing Manual* for codes. The following codes are required on claims with Medicare or other insurance.

A1 Use for Medicare Part A Deductible
A2 Use for Medicare Part A Coinsurance
B1 Use for Medicare Part B Deductible
B2 Use for Medicare Part B Coinsurance

C1 Third Party Payer Deductible
C2 Third Party Payer Coinsurance

The following codes are required on dialysis claims from free-standing and hospital-based dialysis facilities when billing for administration of Erythropoietin (EPO):

49 Hematocrit test results
68 EPO units administered

Situational Codes which should be reported as applicable include:
A8 Patient Weight
A9 Patient Height

**42. Revenue Code** **Required**

Enter the appropriate revenue code(s) that identify a specific accommodation or ancillary service provided. See *AHA Uniform Billing Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES |
|---|---|---|---|
| 1 | 0132 | | |
| 2 | 0251 | | |
| 3 | 0258 | | |
| 4 | | | |

**43. Revenue Code Description** **Required**

Enter the description of the revenue code billed in Field 42. See *AHA Uniform Billing Manual* for description of revenue codes.

## COMPLETING THE UB CLAIM FORM (CONT.)

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES |
|---|---|---|---|
| 1 | | OB/3&4 BED | |
| 2 | | DRUGS/GENERIC | |
| 3 | | IV SOLUTIONS | |
| 4 | | | |

**44. HCPCS Modifier/Rates** **Required if applicable**

If the revenue code is for accommodation enter the inpatient (hospital or nursing facility) accommodation rate. For outpatient Hospitals claims enter the appropriate CPT/HCPCS and modifier codes (See Chapter 11, Hospital Services). If a CPT/HCPCS modifier is required, enter the modifiers (up to 4) immediately following the CPT/HCPCS code. Dialysis facilities must enter the appropriate CPT/HCPCS code for certain lab, radiology, and pharmacy revenue codes (See Chapter 15, Dialysis Services).

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES |
|---|---|---|---|
| 1 | | | 1,088.00 |
| 2 | | | 8559559 |
| 3 | | | 95900 |
| 4 | | | |

**45. Service Date** **Required if Applicable**

**The dates the indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not equal to each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.**

**46. Service Units** **Required**

A quantitative measure of services rendered by revenue/HCPCS code must be indicated for all services. If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.

## COMPLETING THE UB CLAIM FORM (CONT.)

| 46. SERV. UNITS | 47. TOTAL CHARGES | 48. NON-COVERED CHARGES | 49. |
|---|---|---|---|
| 2.00 | | | |
| 3.00 | | | |
| 30.00 | | | |
| | | | |

**47. Total Charges By Revenue Code Line** **Required**

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.

| 46. SERV. UNITS | 47. TOTAL CHARGES | 48. NON-COVERED CHARGES | 49. |
|---|---|---|---|
| | 2,176 00 | | |
| | 104 26 | | |
| | 529 92 | | |
| | | | |

**48. Non-covered Charges** **Required if applicable**

Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

**49. Unassigned** **Not required**

**50.**
**(A–C) Payer Identification** **Required**

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

## COMPLETING THE UB CLAIM FORM (CONT.)

| | 50. PAYER | 51. PROVIDER NO. | 52. REL INFO | | 53. ASG BEN |
|---|---|---|---|---|---|
| A | AHCCCS | | | | |
| B | | | | | |
| C | | | | | |

**51.**
**(A–C) Provider Number** **Required**

Enter the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility's six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.

| | 50. PAYER | 51. PROVIDER NO. | 52. REL INFO | | 53. ASG BEN |
|---|---|---|---|---|---|
| A | | 654321 | | | |
| B | | | | | |
| C | | | | | |

**52.**
**(A–C) Release of Information Certification Indicator** **Not required**

**53.**
**(A–C) Assignment of Benefits Certification Indicator** **Not required**

**54.**
**(A–C) Prior Payments – Payers and Patient** **Required if applicable**

Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If the recipient has other insurance but no payment was received, enter "Ø." The " Ø " indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.

**55.**
**(A–C) Estimated Amount due** **Not required**

## COMPLETING THE UB CLAIM FORM (CONT.)

**56. Unassigned** **Not required**

**57. Unassigned** **Not required**

**58.**
**(A–C) Insured's Name** **Required**

Enter the name of insured (AHCCCS recipient) covered by the payer(s) in Field 50.

| | 58. INSURED'S NAME | 59. P.REL. | 60. CERT. – SSN - HIC. - ID NO. |
|---|---|---|---|
| A | Holliday, John H. | | |
| B | | | |
| C | | | |

**59.**
**(A–C) Patient's Relationship To Insured** **Not required**

**60.**
**(A–C) Certificate/Social Security Number/Health Insurance Claim/Identification Number** **Required**

Enter the recipient's AHCCCS ID number. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

| | 58. INSURED'S NAME | 59. P.REL. | 60. CERT. –SSN - HIC. - ID NO. |
|---|---|---|---|
| A | | | A12345678 |
| B | | | |
| C | | | |

**61.**
**(A–C) Insured Group Name** **Required**

Enter "FFS" for AHCCCS IHS and ESP recipients.

## COMPLETING THE UB CLAIM FORM (CONT.)

| 60. CERT. –SSN - HIC. - ID NO. | 61. GROUP NAME | 62. INSURANCE GROUP NO. |
|---|---|---|
| | FFS | |
| | | |
| | | |

**62.**
**(A–C) Insurance Group Number** **Not required**

**63.**
**(A–C) Treatment Authorization Code** **Not required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 8, Authorizations/IHS Referrals, for information on prior authorization.

**64.**
**(A–C) Employment Status Code** **Not required**

**65.**
**(A–C) Employer Name of the Insured** **Not required**

**66.**
**(A–C) Employer Location of the Insured** **Not required**

**67. Principal Diagnosis Code** **Required**

Enter the principal *ICD-9 diagnosis code*. Behavioral health providers must **not** use DSM-4 diagnosis codes.

| 67. PRIN. DIAG CODE | OTHER DIAG. CODES | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 68. CODE | 69. CODE | 70. CODE | 71. CODE | 72. CODE | 73. CODE | 74. CODE | 75. CODE |
| 585.0 | | | | | | | | |

**68. –**
**75. Other Diagnosis Codes** **Required if applicable**

Enter other applicable ICD-9 diagnosis codes. Include codes for other conditions that existed during the episode of care but were not primarily responsible for admission.

## COMPLETING THE UB CLAIM FORM (CONT.)

**76. Admitting Diagnosis/Patient's Reason for Visit** **Required if applicable**

Required for inpatient bills. Enter the ICD-9 diagnosis code that represents the significant reason for admission.

**77. External Cause of Injury Code (E-Code)** **Required if applicable**

Enter trauma diagnosis code, if applicable.

**78. DRG** **Not required**

**79. Procedure Coding Method** **Not required**

**80. Principal Procedure Code and Dates** **Required if applicable**

Enter the principal ICD-9 procedure code and the date the procedure was performed during the inpatient stay. . Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

**81. Other Procedure Codes and Dates** **Required if applicable**

Enter other procedure codes and dates performed, in descending order of importance.

**82. Attending Physician ID** **Not required**

**83. Other Physician ID** **Not required**

**84. Remarks** **Required if applicable**

Required on resubmissions and voids. Enter the CRN of the claim being resubmitted or voided. For resubmissions of denied claims, write "Resubmission" in this field.

**85. Provider Representative** **Required**

An authorized representative must sign each claim form verifying the certification statement on reverse of claim. Rubber stamp or facsimile signatures are acceptable but must be initialed by a provider representative.

| 85. PROVIDER REPRESENTATIVE | 86. DATE |
|---|---|
| Betsy Ross | |
| I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND MADE A PART HEREOF. | |

## COMPLETING THE UB CLAIM FORM (CONT.)

**86. Date** **Required**

Enter the date the claim is submitted in MM/DD/YY or MM/DD/YYYY format.

| 85. PROVIDER REPRESENTATIVE | 86. DATE |
|---|---|
| | 03/15/02 |
| I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND MADE A PART HEREOF. | |

**or**

| | |
|---|---|
| | 03/15/2002 |
| I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND MADE A PART HEREOF. | |

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